PUBLIC ACCESS DEFIBRILLATION (PAD)

AED USE NOTIFICATION

Directions:
- Please use one form for each AED usage
- Submit to the Santa Clara County EMS Agency within 96 hours of AED use

AED Program Name: ____________________________

Location Information:
Date: ____________________________ Time of Incident ____________________________
Street Address: ____________________________
Patient’s Name (if known): ____________________________
Patient’s Estimated Age: ____________________________ Patient’s Sex: ____________________________

CPR Information:
Was CPR performed? : ☐ Yes ☐ No
Type of CPR performed: ☐ Compressions Only ☐ Compressions and Ventilations
Type of ventilations performed: ☐ Mouth to Mouth ☐ Mouth to Mask ☐ BVM
Name of person(s) providing CPR: ____________________________

Did the AED instruct you to defibrillate (shock) the patient? : ☐ Yes ☐ No
What was the total number of defibrillations (shocks) delivered? : ____________________________

Timeline:

<table>
<thead>
<tr>
<th>Event</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnessed cardiac arrest</td>
<td></td>
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<tr>
<td>Start of CPR</td>
<td></td>
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<tr>
<td>Call to 9-1-1 made</td>
<td></td>
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<tr>
<td>First Defibrillation given</td>
<td></td>
</tr>
<tr>
<td>9-1-1 Arrival to scene</td>
<td></td>
</tr>
</tbody>
</table>

PAD Program Coordinator
Signature: ____________________________ Date: ____________________________